Arizona Dept. of Health Services
Division of Behavioral Health Services

Encounter Tidbits

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Encounter Tidbits is a monthly publication of the Arizona Department of Health Services, Division of Behavioral Health Services, Office of Program Support Services
150 North 18th Avenue, 2nd Floor, Phoenix, AZ 85007
www.hs.state.az.us/bhs

The Division of Behavioral Health Services has moved. Our new address and phone number are:

Behavioral Health Services
150 North 18th Avenue, 2nd Floor
Phoenix, Arizona 85007
(602) 364-4558

Edit Alerts

An Edit Alert is a faxed and e-mailed notice of system enhancements or changes. The Office of Program Support strives to ensure any system enhancements or changes are communicated to all program participants in an accurate and reliable manner. Edit Alerts will be distributed when the information is first made available and again with the following monthly publication of the Encounter Tidbits.

** There are no Edit Alerts this month. **

Sanction Calculations

RBHAs must resolve all AHCCCS pended encounters within 120 days of the original processing date. A new field, Sanction_Date, has been added to the end of the file, which indicates the date each encounter may be sanctioned (121 days following the Pend Date). Sanctions will be imposed according to the following schedule:

0 – 120 days	No sanctions
121 – 180 days	$5.00 per month
181 – 240 days	$10.00 per month
241 – 360 days	$15.00 per month
361 + days	$20.00 per month

Corporate Compliance

Effective October 1, 2003, ADHS and the subcontractors shall be in compliance with 42 CFR 438.608. ADHS and the subcontractors must have a mandatory compliance program, supported by administrative procedures that are designed to guard against fraud and abuse. The compliance program, which will both prevent and detect suspected fraud or abuse, must include:

1. The designation of a compliance officer and a compliance committee.
2. Effective training and education.
3. Effective lines of communication between the compliance officer and the organization's employees.
4. Enforcement of standards through well-publicized disciplinary guidelines.
5. Provision for internal monitoring and auditing.
6. Provision for prompt response to problems detected.

Third Party Liability (TPL)

To determine if a recipient has TPL, use PMMIS and go to screen RP155. This screen will indicate whether the recipient has any other coverage from a third party administrator. If there is a carrier listed on this screen, encounters/claims submitted to AHCCCS for dates of service covered must include third party payment information. TPL refers to the legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under a State plan. Third parties include, but are not limited to: private health insurance, Medicare, employment related health insurance, medical support from non-custodial parents, court judgments or settlements from a liability insurer, State worker's compensation, first party probate-estate recoveries, long term care insurance, and other Federal programs. The Medicaid program by law is intended to be the payer of last resort; that is, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. Individuals eligible for Medicaid assign their rights to third party payments to the State Medicaid agency. States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the State plan.

If the recipient has third party insurance the screen will display:

- Carrier Name
- Carrier Source
- Policy Number
- Coverage Begin and End Date
- Coverage Type
- Change Reason

To view the third party coverage detail, select the line you wish to view and the following information will be displayed:

- Carrier Name and Number
- Carrier Address
- Policy Number and Coverage Type
- Policy Begin and End Date
- Policy Holder's Name
- Policy Holder's SSN
- Relationship of Policy Holder to Recipient

To return to the previous screen, press F2.

AHCCCS Pended Encounters

Deletion & Approved Duplicate File Changes

The new requirements for the August 2003 pend cycle are as follows:

1) One combined file (fixed length, no commas or quotes) will be submitted by each RBHA via the NT server in the following format:

Data Name	Picture	From	To	Remarks
Contractor ID	X(2)	01	02	Zero filled
AHCCCS CRN Number	X(14)	03	16	
ICN Number	X(11)	17	27	
Line Number	X(2)	28	29	Zero filled
Client ID	X(10)	30	39	
Error Code	X(4)	40	43	
Action	X(1)	44	44	'D' = Delete
				'A' = Approve Duplicate Audit
Reason Code	X(4)	45	48	(See Reason Code List)
Resubmit	X(1)	49	49	'N' = No
				'Y' = Yes

2) All fields are required. If any of the fields are missing OR the reason code is not valid OR we cannot associate the record with a current pended encounter, the record will be rejected. Rejected records will be written to an exception file and distributed to the RBHAs via the NT server.
3) The single file will be called DELDUPyyyymm_rr.TXT (yyyymm is the pend cycle 4-digit year and 2-digit month, rr is the 2 character RBHA ID (zero filled)). Example: For ValueOptions' pend cycle April 2003, the file name would be DelDup200304_08.txt.
4) The following is a list of valid Reason Codes:

Associated Action	Reason Code	Description
A	A001	Per RBHA review, not a duplicate encounter
D	D001	Encounter submitted in error
D	D002	Duplicate encounter
D	D003	Combining service with a previous encounter
D	D004	Medicare/TPL paid encounter in full
D	D005	Correcting a RBHA system error
D	D006	Re-pricing encounter
D	D007	Reporting encounter as Tobacco Tax Fund
D	D008	Correcting AHCCCS pended encounter
D	D009	Conflicting HCFA-1500 / UB-92 encounters
D	D010	Medicare coverage indicated but not billed
D	D011	Rate not on Provider table
D	D012	Recipient not AHCCCS eligible during dates of service
D	D013	Provider terminated or not valid during dates of service
D	D014	Units exceed maximum allowed
D	D015	Reporting encounter as Subvention (State funds)
D	D016	Service for IHS Provider should be billed through TRBHA

AHCCCS Encounters Error Codes

R600 – Medicare Coverage Indicated But Not Billed

Encounters are pending because the TPL file indicates the recipient has Medicare coverage, but the claim has been submitted with the Medicare fields blank. If the TPL file indicates a recipient has Medicare, claims must be submitted with a dollar amount. If the service is not a Medicare covered service, zero must be entered in the Medicare fields. A zero value indicates Medicare did not cover or denied the service.

P295 – Service Provider Terminated During Service Date Span

Encounters are pending because the AHCCCS system indicates the billing provider's enrollment status as terminated prior to the billed dates of service. Providers can check their enrollment status in PMMIS PR070.

P330 – Provider Not Eligible for Category of Service on Service Date

Encounters will pend when the provider is not eligible to bill for the indicated category of service on the date service was provided. RBHA's should ensure the category of service matches the provider type (on the date of service) prior to submitting the encounter.

Z575 – Date of Service Already Billed on an Outpatient from Different Health Plan

Encounters are pending because the admit hour on an inpatient encounter is prior to discharge hour on the competing encounter. If an outpatient encounter was submitted for DOS 11/06/2002 – 11/06/2002 with a discharge hour of '11' and an inpatient encounters is submitted for the same client and a different provider with DOS 11/06/2002 – 11/13/2002 and an admit hour of '10'. This would indicate the client was in two different facilities at the same time. Coordination of care must be communicated between the RBHAs and the other involved health plan.

These four errors account for ***64%*** of the pended encounters at AHCCCS.

Demographic File Reminders

When submitting demographic files on a client, only one submission may be submitted per client per day. Demographic files must also be submitted in the correct order.

Example: You have two demographic file diagnosis code changes to submit on a client, one dated 02/05/2003 and one dated 03/05/2003. The file dated 02/05/2003 must be submitted first on one day and the 03/05/2003 file must be submitted on a separate subsequent day.

Category of Service

For most provider types there are mandatory as well as optional AHCCCS Categories of Services (COS). In addition to the provider type, the COS will determine the specific services for which the provider can bill. For purposes of behavioral health, the following COSs are relevant:

01 Medicine	15 Durable Medical Equipment
06 Physical Therapy	16 Outpatient Facility Fees
09 Pharmacy	18 Skilled Nursing Facility
10 Inpatient Hospital	26 Respite Care Services
12 Pathology & Laboratory	31 Non-Emergency Transportation
13 Radiology	47 Mental Health Services
14 Emergency Transportation	

In order to qualify for some of these COSs the providers may have to meet additional licensing/certification requirements. It is important for providers when registering to make sure they qualify and register for the necessary COS that will allow them to bill the desired service codes.

Additional information as well as registration materials may be obtained by calling the AHCCCS Provider Registration Unit at (602) 417-7670 (option 5) or 1-800-794-6862.

Fraud and Abuse Reporting

Please ensure providers and members know how and where to report fraud and abuse. It is our objective to be proactive in the prevention and detection of fraud and abuse in the Behavioral Health System. Those wanting to report possible fraudulent activity may do so by contacting their RBHA Fraud and Abuse coordinator, or may report directly to Stacy Mobbs (Fraud and Abuse Coordinator, Division of Behavioral Health Services) at (602) 364-4558. Callers may remain anonymous. Also, any open cases at the RBHA's should be referred immediately to the Division of Behavioral Health Services.

What is a Community Service Agency?

Community Service Agencies are entities that provide support. Examples of Community Service Agencies might include a halfway house, YMCA, Boys and Girls Club, Big Brothers/Big Sisters, Girl Scouts, domestic violence shelter, consumer drop in center, clubhouse, or faith-based organizations. Many of these agencies may have been registered as BHS only provider type S1, but these registrations are no longer valid. Agencies must now be registered through AHCCCS. They will still need to go through BHS to receive a Community Service Agency TXIX Certificate but then must submit this Community Service Agency TXIX Certificate as part of their registration packet to AHCCCS requesting registration as a Community Service Agency, provider type A3. This will help us to maximize Title XIX/XXI monies. Please note that OBHL licensed outpatient agencies do not have to be certified as Community Service Agencies in order to provide support services.

Billing Questions…

How can a provider bill for the cost of travel associated with a staff person traveling to and from the service delivery site? In addition to mileage, can a provider bill for the staff's travel time?

For services provided in an out-of-office setting and billed as w-codes (i.e., W2151, W2152, W2351, W4003, W4005, W4001, W4002, W4006, W4015, W4031, W4041, W4043, W4044, W4045, W4046, W4047, W4048, W4049), the first 25 miles of provider travel cost has been included in the fee-for-service rate. For services in which mileage incurred by the provider exceeds 25 miles, the provider may bill A0160 for the additional mileage incurred. (See the Covered Behavioral Health Services Guide under Section 1.C.3 – Billing for Services for examples of how this code may be used.) Only the following provider types may bill A0160: non-emergency transportation provider (28), T/RBHAs (72), outpatient clinic (77), Community Service Agency (A3) and Rural Substance Abuse Transitional Center (A6). Independent practitioners who bill CPT/HCPCS codes cannot bill A0160 and should ensure that travel costs are included in their negotiated rates.

The provider would not bill for the staff person's travel time to and from an out-of-office service delivery site as this time is accounted for in the fee-for-service rates for these services. The provider may only bill for time spent in providing the actual service.

User Access Request Forms

The Office of Program Support Services must authorize all requests for access to CIS, Office of Human Rights, Office of Grievance and Appeals, and PMMIS (AHCCCS) databases. In order to obtain access to any of these databases, please fax a copy of the appropriate User Access Request Form and User Affirmation Statement to Stacy Mobbs at (602) 364-4736. For questions, please contact Stacy Mobbs by telephone at (602) 364-4708 or by e-mail at smobbs@hs.state.az.us.

Office of Program Support Staff

If assistance is needed, please contact your assigned Technical Assistant at:

Michael Carter	NARBHA PGBHA	(602) 364-4710
Eunice Argusta	CPSA-3 CPSA-5	(602) 364-4711
Javier Higuera	Excel Value Options	(602) 364-4712